

### Motor Vehicle Collision Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

H. Phone \_\_\_\_\_ Work. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M F Marital Status M S D W

Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Auto Insurance Company \_\_\_\_\_ Insurance Company Phone # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Claim # \_\_\_\_\_ Policy Holder Name \_\_\_\_\_

Auto Adjuster Name \_\_\_\_\_ Direct Phone # \_\_\_\_\_

Date of Injury \_\_\_\_\_ State of Injury \_\_\_\_\_

Have you ever received Chiropractic Care? YES NO If yes, when? \_\_\_\_\_

Name of most recent Chiropractor: \_\_\_\_\_

Please describe how the accident occurred

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**1. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

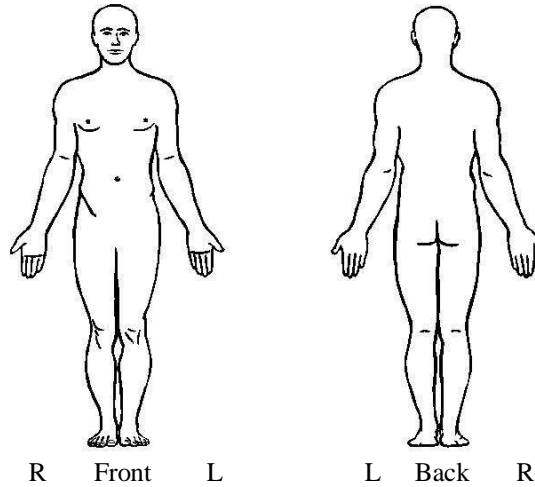
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. Since the Motor Vehicle Collision, have you experienced any of the following:**

- A. Loss of Range of Motion: yes/no
  - a. What body parts: \_\_\_\_\_
- B. Visual Disturbance: yes/no
  - blurring l/r     floaters l/r     vision loss l/r     hypersensitivity l/r
  - % of time: \_\_\_\_ % of time: \_\_\_\_ % of time: \_\_\_\_ % of time: \_\_\_\_
- C. Dizziness: yes/no % of time: \_\_\_\_
- D. Anxiety: yes/no % of time: \_\_\_\_
- E. Depression: yes/no % of time: \_\_\_\_
- F. Difficulty Sleeping: yes/no

Doctor Signature: \_\_\_\_\_

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Dr. Howard Johnson, D.C.



Place a X everywhere you are experiencing pain since the motor vehicle accident.

**3. Past Health History:**

**A. Please indicate if you have a history of any of the following:**

- Anticoagulant use    Heart problems/high blood pressure/chest pain    Bleeding problems
- Lung problems/shortness of breath    Cancer    Diabetes    Psychiatric disorders
- Bipolar disorder    Major depression    Schizophrenia    Stroke/TIA's    Other \_\_\_\_\_
- None of the above

**B. Previous Injury or Trauma:**

\_\_\_\_\_

**Have you ever broken any bones? Which?**

\_\_\_\_\_

**C. Allergies:** \_\_\_\_\_

**D. Medications:**

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

**E. Surgeries:**

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

Doctor Signature: \_\_\_\_\_

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**F. Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

**4. Family Health History:**

Do you have a family history of? (Please indicate all that apply)

- Cancer    Strokes/TIA's    Headaches    Cardiac disease    Neurological diseases
- Adopted/Unknown    Cardiac disease below age 40    Psychiatric disease    Diabetes
- Other \_\_\_\_\_    None of the above

Deaths in immediate family: \_\_\_\_\_

Cause of parents or siblings' death	Age at death
_____	_____
_____	_____
_____	_____

**5. Social and Occupational History:**

**A. Job description:**

\_\_\_\_\_

**B. Work schedule:**

\_\_\_\_\_

**C. Recreational activities:**

\_\_\_\_\_

**D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

\_\_\_\_\_

Doctor Signature: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Have you had any of the following **pulmonary (lung-related)** issues?

- Asthma/difficulty breathing    COPD    Emphysema    Other \_\_\_\_\_    None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

- Heart surgeries    Congestive heart failure    Murmurs or valvular disease    Heart attacks/MIs    Heart disease/problems    Hypertension    Pacemaker    Angina/chest pain    Irregular heartbeat    Other \_\_\_\_\_  
 None of the above

Have you had any of the following **neurological (nerve-related)** issues?

- Visual changes/loss of vision    One-sided weakness of face or body    History of seizures    One-sided decreased feeling in the face or body    Headaches    Memory loss    Tremors    Vertigo    Loss of sense of smell  
 Strokes/TIAs    Other \_\_\_\_\_    None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

- Thyroid disease    Hormone replacement therapy    Injectable steroid replacements    Diabetes  
 Other \_\_\_\_\_    None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

- Renal calculi/stones    Hematuria (blood in the urine)    Incontinence (can't control)    Bladder Infections  
 Difficulty urinating    Kidney disease    Dialysis    Other \_\_\_\_\_    None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

- Nausea    Difficulty swallowing    Ulcerative disease    Frequent abdominal pain    Hiatal hernia    Constipation  
 Pancreatic disease    Irritable bowel/colitis    Hepatitis or liver disease    Bloody or black tarry stools  
 Vomiting blood    Bowel incontinence    Gastro-esophageal reflux/heartburn    Other \_\_\_\_\_    None of the above

Have you had any of the following **hematological (blood-related)** issues?

- Anemia    Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)    HIV positive  
 Abnormal bleeding/bruising    Sickle-cell anemia    Enlarged lymph nodes    Hemophilia  
 Hypercoagulation or deep venous thrombosis/history of blood clots    Anticoagulant therapy    Regular aspirin use  
 Other \_\_\_\_\_    None of the above

Have you had any of the following **dermatological (skin-related)** issues?

- Significant burns    Significant rashes    Skin grafts    Psoriatic disorders    Other \_\_\_\_\_    None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

- Rheumatoid arthritis    Gout    Osteoarthritis    Broken bones    Spinal fracture    Spinal surgery    Joint surgery  
 Arthritis (unknown type)    Scoliosis    Metal implants    Other \_\_\_\_\_    None of the above

Have you had any of the following **psychological** issues?

- Psychiatric diagnosis    Depression    Suicidal ideations    Bipolar disorder    Homicidal ideations    Schizophrenia  
 Psychiatric hospitalizations    Other \_\_\_\_\_    None of the above

Is there anything else in your past medical history that you feel is important to your care here? \_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Power Within Chiropractic of Elk River for services performed.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature: \_\_\_\_\_

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Dr. Howard Johnson, D.C.

**HIPAA NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

**Use and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

Doctor Signature: \_\_\_\_\_

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**NEW PATIENT SYMPTOM FORM**

*Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.*

Symptom 1 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
  - **Did you have this symptom before this motor vehicle collision?** Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Doctor Signature: \_\_\_\_\_

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Symptom 2 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
  - **Did you have this symptom before this motor vehicle collision?** Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

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Symptom 3 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
  - **Did you have this symptom before this motor vehicle collision?** Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Doctor Signature: \_\_\_\_\_

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Symptom 4 \_\_\_\_\_

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
  - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
  - **Did you have this symptom before this motor vehicle collision?** Yes/No
    - If so, what was the intensity (1-10 w/10 the worst) and frequency? \_\_\_\_\_
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): \_\_\_\_\_
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): \_\_\_\_\_
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): \_\_\_\_\_
- Does the symptom radiate to another part of your body (circle one):    yes    no
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning    Afternoon    Evening    Night    Unaffected by time of day

Doctor Signature: \_\_\_\_\_

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**PATIENT CONSENT FOR CHIROPRACTIC TREATMENT**

**To the patient:** Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask your Doctor any questions that you have about the information below. You can ask questions at any time before, during, or after your treatment.

**The nature of chiropractic adjustment:** The primary treatment your Doctors of Chiropractic uses is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible “pop” or “click”, much as you have experienced when you “crack” your own knuckles. You may also feel a sense of movement.

**Examination and Treatment:** In addition to spinal manipulation, we may use a variety of other therapies and examination procedures. As a part of the analysis, examination, and treatment, you are consenting to the following additional procedures:

- |   |  |
|---|--|
| <input type="checkbox"/> spinal manipulative therapy  | <input type="checkbox"/> palpation                               |
| <input type="checkbox"/> vital signs                  | <input type="checkbox"/> orthopedic testing                      |
| <input type="checkbox"/> range of motion testing      | <input type="checkbox"/> basic neurological exam                 |
| <input type="checkbox"/> muscle strength testing      | <input type="checkbox"/> ultrasound                              |
| <input type="checkbox"/> radiographic studies         | <input type="checkbox"/> Rehabilitation/Core strengthening       |
| <input type="checkbox"/> nutritional therapy          | <input type="checkbox"/> mechanical traction/flexion distraction |
| <input type="checkbox"/> Other (please explain) _____ |  |

We will explain these procedures to you and answer any questions you have about them.

**The material risks inherent in chiropractic adjustment:** Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

**The probability of risks occurring:**

**Soreness:** It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you may experience after exercise.

**Fracture:** Fractures caused from spinal manipulations are extremely rare. It is so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation may be utilized for this type of patient.

**Ruptured/Herniated Disc:** There have been some reports of herniated or ruptured discs caused by spinal manipulations. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.

**TIA/Stroke:** According to the literature, possible neurological complications can arise in 1 per 1-8 million office visits or 1 per 2-5.85 million adjustments. Screening tests are performed when necessary to rule out high-risk patients. Alternative spinal adjusting is utilized when necessary to minimize any potential risks.

**Other complications:** These include but are not limited to: dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

Doctor Signature: \_\_\_\_\_

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**The availability of other treatment options:** Other treatment options for your condition may include:

- Self-administered, over-the-counter medications
- Medical care and prescription drugs, such as anti-inflammatories, muscle relaxants, and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted “other treatment” options, you should be aware that there are also risks and benefits with each one of those options and you may wish to discuss these with your primary medical physician.

**The risks and dangers associated with remaining untreated:** Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**Notices of Privacy Practices:** Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Notice of Privacy Practices. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

**Consent to Release of Information:**

- In accordance with Minnesota Statutes § 144.335, I consent to the release by my provider of my health records and medical information about me to physicians, providers, and staff as necessary for treatment, to insurers as necessary to receive payment for services, and to third parties for purposes of reviewing quality of care and for health care operations (so long as the release is in compliance with applicable law), including releases for internal or external audits, research and quality assurance, or licensing/accreditation purposes.
- I give my permission to my provider to communicate information about me to those people involved in my care for the purpose of my treatment as designated in my medical record.
- I give permission for my provider to communicate with me regarding my medical care, such as results of tests/reports through voicemail messages via the phone numbers I have supplied in my medical record.
- In order to assure proper quality and continuity of care, I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, or third party administrators to share my health records and information obtained from my health care provider or any other provider, with my health care provider, other providers from whom I have received services, or any other payer, payer network organization, or third party administrators as needed for payment and health care operations.

I understand this Consent to Release of Information does not expire unless I revoke it or provide a specific expiration date here:  
\_\_\_\_\_

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. BY SIGNING BELOW, I CONSENT TO ALL OF THE USES AND DISCLOSURES ABOVE, AND I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.**

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my provider and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I do not expect the doctor to be able to anticipate and explain all the risks and complications. Having been informed of the known risks, I hereby give my consent to that treatment. I intend this consent to apply to all of my present and future chiropractic care.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or authorized person

\_\_\_\_\_  
Authority to act on behalf of patient

Doctor Signature: \_\_\_\_\_

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